IPDR6702				NORTH CAROLINA	1	PAGE:	1	
RUN DATE:	10/16/2005			CHECKWRITE SUMMARY REPORT CKWRITE DATE: 10/18/2005				
				FINANCIAL PAYER: NCDMH				
PROVIDER		HIGH DENIAL	NUMBER OF		muc	moma r	TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	TNC DENIALS	TOTAL DENIALS	CLAIMS FINALIZED	CLAIMS
3404901	SMOKY MOUNTAINM	0	0	*** NO DATA TO REPORT ***				
	H/DD/SAS							
		0	0		0	0	0	0
3404904	WESTERN HIGHLAN	8599	97	DETAIL NOT COVERED BY COMBINAT				
	DS LME			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		21	76	DUPLICATE OF CLAIM-SYSTEM	3	221	2800	2579
					-	221	2000	2573
		5308	12	PRIOR AUTHORIZED UNITS EXCEEDE				
		3300		D				
24040**		10	0.0	DIACNOSTO OD CEDUTOR ANTHER				
3404910	PATHWAYS	10	90	DIAGNOSIS OR SERVICE INVALID F OR CLIENT AGE. VERIFY CID,	1			
				DIAGNOSIS, PROCEDURE CODE FOR				
		8599	29	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	3	176	3491	3290
		+	1	BENEFIT PACKAGE.	 			
		11	27	CLIENT NOT ELIGIBLE ON SERVICE				
				DATE				
3404912	CATAWBA COUNTYM	8931	19	AMTNC INELIGIBLE TO RECEIVE SE				
	ENTAL HEALT			RVICES IN IPRS.				
		8599	4	DETAIL NOT COVERED BY COMBINAT	22	33	353	320
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		191	4	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
3404913	MECKLENBURG COM	11	6045	CLIENT NOT ELIGIBLE ON SERVICE				
	ENTAL HEALT			DATE				
		8933	1405	ADTNC INELIGIBLE TO RECEIVE SE	1.050	0042	07.64	722
				RVICES IN IPRS.	1650	8042	8764	122
		95.00	126	DETAIL MOT COURDED BY COMPINED				
		8599	136	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	 			
				BENEFIT PACKAGE.				
24040**		0500	26	DETERM NOT COURDED BY COMPANY				
3404916	CROSSROADS BEHA	8599	36	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND	1			
	VIORAL HEAL	+		BENEFIT PACKAGE.	 			
		21	33	DUPLICATE OF CLAIM-SYSTEM	0	152	4452	4300
		+	1		 			
		10	29	DIAGNOSIS OR SERVICE INVALID F				
		+		OR CLIENT AGE. VERIFY CID, DIAGNOSIS, PROCEDURE CODE FOR	1			
		1			1			
3404917	CENTERPOINT HUM	21	4017	DUPLICATE OF CLAIM-SYSTEM				
	AN SERVICES	1	1		1			
		+	1		 			
		10	675	DIAGNOSIS OR SERVICE INVALID F	35	5731	14743	9012
				OR CLIENT AGE. VERIFY CID, DIAGNOSIS, PROCEDURE CODE FOR				
		+		DIAGNOSIS, PROCEDURE CODE FOR	1			
		8599	598	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
	1	1	1				1	

							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404918		0	0	*** NO DATA TO REPORT ***				
3404310	ROCKINGHAM CO M	0	U	NO DATA TO REPORT				
	ENTAL HEALT							
		0	0		0	0	0	
						Ü		
3404919	GUILFORD CO MEN	8536	504	ATTENDING PROVIDER TYPE AND SP				
	TAL HEALTHC			ECIALTY COMBINATION IS NOT				
				VALID FOR SUBMITTED BILLING PR				
		79	362	THIS SERVICE IS NOT PAYABLE TO	150	1314	6532	521
				YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
		8599	122	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
				BENEFII FACRAGE.				-
3404920		8502	711	CLAIM DENIED DUE TO INSUFFICIE				-
3404320	ALAMANCE CASWEL	0302	/11	NT ALLOTMENT				
	L AREA MH D			112 11220 112211 1				
	+		-	+	1		 	+
	+	0	0	+		711	723	
	+		-	+	1	/11	723	†
			-	<u> </u>				
3404921	ORANGE PERSON C	8800	90	FURTHER PROCESSING NECESSARY,				1
	HATHAM AREA			PLEASE CHECK FOR CLAIM ON				T
	1			FUTURE RA'S.				t
								t
		191	83	CLIENT ID NUMBER DOES NOT MATC	22	491	3257	276
				H PATIENT NAME				
		8505	72	CLAIM DENIED DUE TO INSUFFICIE				
				NT BUDGET				
3404922	THE DURHAM CENT	8329	162	CLAIM DENIED ATTENDING PROVIDE				
	ER			R CANNOT BE THE SAME AS				
				THE LMA				
		0505						
		8535	4	SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837.	0	168	192	2
				PLEASE RESUBMIT YOUR CLAIM WIT				-
		191	2	CLIENT ID NUMBER DOES NOT MATC				-
		191	2	H PATIENT NAME				-
				n FAIIBNI WAME				
3404923	DTIP COUNTY MI	8536	138	ATTENDING PROVIDER TYPE AND SP				
	FIVE COUNTY MH			ECIALTY COMBINATION IS NOT				
				VALID FOR SUBMITTED BILLING PR				
		79	29	THIS SERVICE IS NOT PAYABLE TO	0	240	2784	254
				YOUR SUBMITTED BILLING	Ů	240	2704	234
				PROVIDER TYPE AND SPECIALTY IN				t
								1
		21	20	DUPLICATE OF CLAIM-SYSTEM				t
3404925	SANDHILLS CENTE	8534	2982	SERVICE FACILITY LOCATION IS N				
	R FOR MH/DD			OT A VALID IPRS ATTENDING				ļ
				PROVIDER. PLEASE VERIFY THE F			ļ	
		0505						
	1	8536	1935	ATTENDING PROVIDER TYPE AND SP	185	8561	23455	1489
	1			ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR				
	1		-	VALUE FOR SUBMITTED BILLING PK	1			-
		79	1556	THIS SERVICE IS NOT PAYABLE TO				!
		. 3	1330	YOUR SUBMITTED BILLING				-
			-	PROVIDER TYPE AND SPECIALTY IN				-
	+		+					+
3404926	COMMUNICATION COMPANY COM	21	2768	DUPLICATE OF CLAIM-SYSTEM	-		1	
	SOUTHEASTERN RE	1	1		1		 	
	G MENTAL HL		-	+	1		 	+
	+		-	+	1		 	+
	+	8599	761	DETAIL NOT COVERED BY COMBINAT	976	5550	11749	619
	+		1	ION OF RECIPIENT, PROVIDER AND	9/6	5350	11/49	019
	+		-	BENEFIT PACKAGE.				
	+		-	+				
-	+	8931	604	AMTNC INELIGIBLE TO RECEIVE SE				t
				RVICES IN IPRS.				
				RVICES IN IPRS.				

							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404927	CUMBERLAND CO M	8599	1	DETAIL NOT COVERED BY COMBINAT				
	HC			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		0	0			1	2	
3404929	LEE HARNETT MH/	0	0	*** NO DATA TO REPORT ***				
	DD/SAS							
		0	0			0	0	
								,
3404930	JOHNSTON COUNTY	8505	142	CLAIM DENIED DUE TO INSUFFICIE				
	MNTL HLTHC			NT BUDGET				
		8800	4	FURTHER PROCESSING NECESSARY,		146	146	(
				PLEASE CHECK FOR CLAIM ON				
				FUTURE RA'S.				
3404931	MAKE OF HEL SIG	21	400	DUPLICATE OF CLAIM-SYSTEM			 	
	WAKE CO HUM SVC						 	
	BILLING OF			+		1	 	
				<u> </u>				
		8599	145	DETAIL NOT COVERED BY COMBINAT	4	2 807	5870	5063
				ION OF RECIPIENT, PROVIDER AND		307	2370	
				BENEFIT PACKAGE.				
		8952	98	CLAIM DENIED DUE TO AGE RESTRI				
				CTIONS FOR TARGET POPULATION				
3404932		0	0	*** NO DATA TO REPORT ***				
3404932	RANDOLPH/SANDHI	U	U	NO DATA TO REPORT				
	LLS CO MH C							
		0	0			1 0	0	
							, and the second	,
3404933	SOUTHEASTERN CT	120	106	CLIENT ID NUMBER MISSING OR IN				
	R FOR MH/DD			VALID. ENTER CID AND SUBMIT				
				AS A NEW CLAIM				
		11	32	CLIENT NOT ELIGIBLE ON SERVICE DATE		2 253	4011	3758
				DATE				
		8000	31	NO RATE AVAILABLE ON FILE TO P				
				RICE THIS CLAIM DETAIL				
3404934	ONSLOW CARTERET	8535	647	SERVICE FACILITY LOCATION WAS				
	BEHAV HEAL			NOT INCLUDED IN YOUR 837.				
				PLEASE RESUBMIT YOUR CLAIM WIT		1		
		0500	0.4					
		8599	94	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND		830	1465	635
	1	1			1		1	
							1	l
-				BENEFIT PACKAGE.				
		21	31					
		21	31	DUPLICATE OF CLAIM-SYSTEM				
		21	31					
		21	31					
3404935	WAYNE CO MENTAL	21	31					
3404935	WAYNE CO MENTAL HEALTH CTR	21	31	DUPLICATE OF CLAIM-SYSTEM				
3404935		21	31	DUPLICATE OF CLAIM-SYSTEM				
3404935		21	31	DUPLICATE OF CLAIM-SYSTEM				
3404935		0	0 0	DUPLICATE OF CLAIM-SYSTEM		3 0	0	
3404935		21	0	DUPLICATE OF CLAIM-SYSTEM			0	
	HEALTH CTR	0	0	DUPLICATE OF CLAIM-SYSTEM		0	0	
3404935	HEALTH CTR	21 0 0 0 0 8931	31	DUPLICATE OF CLAIM-SYSTEM *** NO DATA TO REPORT *** AMTINC INELIGIBLE TO RECEIVE SE		0	0	(
	HEALTH CTR	0	0	DUPLICATE OF CLAIM-SYSTEM		0	0	(
	HEALTH CTR	0	0	DUPLICATE OF CLAIM-SYSTEM *** NO DATA TO REPORT *** AMTINC INELIGIBLE TO RECEIVE SE		3 0	0	(
	HEALTH CTR	0 0 8931	0	DUPLICATE OF CLAIM-SYSTEM *** NO DATA TO REPORT *** AMTINC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.		0 0	0	(
	HEALTH CTR	0	0	DUPLICATE OF CLAIM-SYSTEM *** NO DATA TO REPORT *** AMTINC INELIGIBLE TO RECEIVE SE	3	0	0	1200
	HEALTH CTR	0 0 8931	0	DUPLICATE OF CLAIM-SYSTEM *** NO DATA TO REPORT *** ANTINC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. DETAIL NOT COVERED BY COMBINAT	3	0 0	0	120
	HEALTH CTR	0 0 8931	0	DUPLICATE OF CLAIM-SYSTEM *** NO DATA TO REPORT *** AMTINC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	3	3 54	0	120+
	HEALTH CTR	0 0 8931	0	DUPLICATE OF CLAIM-SYSTEM *** NO DATA TO REPORT *** AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. DETAIL NOT COVERED BY COMBINAT ION OF RECEIPENT, PROVIDER AND	3	0 0	0	1204
	HEALTH CTR	0 0 0 0 8931 8599	0	DUPLICATE OF CLAIM-SYSTEM *** NO DATA TO REPORT *** AMTINC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	3	3 54	0	120-
	HEALTH CTR	0 0 0 0 8931 8599	0	DUPLICATE OF CLAIM-SYSTEM *** NO DATA TO REPORT *** AMTINC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	3	3 54	0	120-

			1	T				
PROVIDER		HIGH DENIAL	NUMBER OF		marc	moma r	TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	TNC	TOTAL DENIALS	CLAIMS FINALIZED	PAID
	PROVIDER NAME				DENTALS	DENIALS	FINALIZED	PAID
3404937	EDGECOMBE NASH	21	63	DUPLICATE OF CLAIM-SYSTEM				
	MNTL HLTH C							
	,							
		8599	12	DETAIL NOT COVERED BY COMBINAT	0	75	133	58
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404938	VGFW DBA RIVERS	0	0	*** NO DATA TO REPORT ***				
	TONE COUNSE							
		0	0					
		0	0		0	0	0	0
3404939	NEUSE MENTAL HE	8599	95	DETAIL NOT COVERED BY COMBINAT				
	ALTH CENTER			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8622	11	60 RESIDENTIAL LEVEL II TREATM	0	113	1259	1146
				ENT RECEIVED, PA IS REQUIRED				
				FOR ADDITIONAL SERVICE.				
		24	4	PROCEDURE CODE, PROCEDURE/MODI				
				FIER COMBINATION OR PROCEDURE				
		_		CODE/TYPE OF SERVICE COMBINATI				
0.10.10		100	500					
3404941	PITT CO MH/DD/S	120	580	CLIENT ID NUMBER MISSING OR IN				
	AS CENTER	1		VALID. ENTER CID AND SUBMIT				
		1		AS A NEW CLAIM		1		
		8599	68	DETAIL NOT COVERED BY COMBINAT	17	697	1785	
		0333	00	ION OF RECIPIENT, PROVIDER AND	17	697	1785	1088
				BENEFIT PACKAGE.				
		191	17	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
3404942	ROANOKE CHOWANH	8599	33	DETAIL NOT COVERED BY COMBINAT				
	UMAN SERVIC			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8952	26	CLAIM DENIED DUE TO AGE RESTRI	9	100	1852	1752
				CTIONS FOR TARGET POPULATION				
		21	25					
		21	25	DUPLICATE OF CLAIM-SYSTEM				
3404943	AT DEMADTE MENTS	8599	134	DETAIL NOT COVERED BY COMBINAT				
	ALBEMARLE MENTA L HEALTH CE			ION OF RECIPIENT, PROVIDER AND				
	I IIIIIIII OI			BENEFIT PACKAGE.				
		8534	121	SERVICE FACILITY LOCATION IS N	1.3	355	1086	731
				OT A VALID IPRS ATTENDING				
				PROVIDER. PLEASE VERIFY THE F				
		21	64	DUPLICATE OF CLAIM-SYSTEM				
		1				ļ		
		1				ļ		
2404044		21	11475	DUDITCATE OF CLAIM-CVCTPM				
3404944	EASTPOINTE HUMA	21	11475	DUPLICATE OF CLAIM-SYSTEM		-		
	N SERVICES	1	1			-		-
		+						
		8599	1584	DETAIL NOT COVERED BY COMBINAT	137	15338	23504	8166
				ION OF RECIPIENT, PROVIDER AND	137	15538	23304	0100
		1		BENEFIT PACKAGE.				
		191	1248	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
3404946	FOOTHILLS AREAM	8329	464	CLAIM DENIED ATTENDING PROVIDE				
3404946	FOOTHILLS AREAM ENTAL HEALT	8329	464	CLAIM DENIED ATTENDING PROVIDE R CANNOT BE THE SAME AS				
3404946		8329	464	CLAIM DENIED ATTENDING PROVIDE				
3404946				CLAIM DENIED ATTENDING PROVIDE R CARNOT BE THE SAME AS THE LMA				
3404946		8329	464	CLAIM DENIED ATTENDING PROVIDE R CANNOT BE THE SAME AS THE LMA CLAIM DENIED, SUBMITTED BEYOND	0	477	486	9
3404946				CLAIM DENIED ATTENDING PROVIDE R CANNOT BE THE SAME AS THE LMA CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR	0	477	486	9
3404946				CLAIM DENIED ATTENDING PROVIDE R CANNOT BE THE SAME AS THE LMA CLAIM DENIED, SUBMITTED BEYOND	0	477	486	9
3404946		8518		CLAIM DENIED ATTENDING PROVIDE R CANNOT BE THE SAME AS THE LMA CLAIM DENIED, SUBMITTED BEYOND FILING TIMBLIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE	0	477	486	9
3404946				CLAIM DENIED ATTENDING PROVIDE R CANNOT BE THE SAME AS THE LMA CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR	0	477	486	9
3404946		8518		CLAIM DENIED ATTENDING PROVIDE R CANNOT BE THE SAME AS THE LMA CLAIM DENIED, SUBMITTED BEYOND FILING TIMBLIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE CLIENT ID NUMBER DOES NOT MATC	0	477	486	9

			1	1				
							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404957	TIDELAND MENTAL	191	19	CLIENT ID NUMBER DOES NOT MATC				
	HEALTH CTR			H PATIENT NAME				
ı								
		8599	10	DETAIL NOT COVERED BY COMBINAT	9	55	1806	1751
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		21	10	DUPLICATE OF CLAIM-SYSTEM				
3404979	NEW RIVER AREAM	21	111	DUPLICATE OF CLAIM-SYSTEM				
	H/DD/SA PRO							
		191	2	CLIENT ID NUMBER DOES NOT MATC	0	113	566	453
				H PATIENT NAME				